

FILED MAR 22 1956

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10632

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2116

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2116	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 37 yrs.		c. CITY OR TOWN St. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 4208 E. Cote Brillante			
3. NAME OF DECEASED (Type or Print) a. (First) Josephine		b. (Middle) _____		c. (Last) Dozier		4. DATE OF DEATH (Month) (Day) (Year) 2 26 56	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 1, 1907	
9. AGE (In years last birthday) 49		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid			10b. KIND OF BUSINESS OR INDUSTRY Wall Building		11. BIRTHPLACE (City and State or Foreign Country) New Haven, Connecticut		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME William Nicholas			13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE Wilbert Dozier		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 494-26-6571		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wilbert Dozier 4208 E. Cote Brill.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive vascular disease, malignant. INTERVAL BETWEEN ONSET AND DEATH Undt. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive encephalopathy.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 334X -447X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-22- , 19 56 , to 2-26- , 19 56 , that I last saw the deceased alive on 2-26- , 19 56 , and that death occurred at 1:40a.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. B. Williams M.D.				23b. ADDRESS 2601 N. Whittier Street		23c. DATE SIGNED 2-27-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/2/56		24c. NAME OF CEMETERY OR CREMATORY Calvaryd Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. FEB 28 1956		REGISTRAR'S SIGNATURE J. Carl Smith m.d.		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates		ADDRESS 4107 Finney	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Arthur L. Heald*

Licensed Embalmer No. *4*

P. O. Address *4107*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.